Kathryn Leydon (NDHB)

From: [redacted] (NDHB)
Sent: Monday, 14 August 2017 11:15
To: [redacted] (NDHB); [redacted]
Cc: [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB)
Subject: RE: Northland Diabetes Operational Working Group

Follow Up Flag: Follow up
Flag Status: Completed

Kia ora all,

Unfortunately, upon further investigations, there are an additional 11 patients who have been added to the original HDC complaint [redacted]

Again, this draws attention to previously raised concerns regarding patient safety, quality and performance.

Name	Assigned	Received	Accepted	Closed	Referral timeframes (days)			
					Assigned to viewed/received	Received to accepted	Accepted to close	Assigned to close
[redacted]	11/03/16	1/06/16	24/02/17	24/02/17	82	268	0	350
[redacted]	23/08/16	1/10/16	24/02/17	24/02/17	39	146	0	185
[redacted]	1/10/15	11/11/15	13/11/15	15/03/17	41	2	488	531
[redacted]	15/05/15	19/05/15	10/07/17	10/07/17	4	783	0	787
[redacted]	30/06/15	11/08/15	10/07/17	10/07/17	42	699	0	741
[redacted]	9/06/15	20/08/15	10/07/17	10/07/17	72	690	0	762
[redacted]	12/11/15	10/05/16	10/07/17	10/07/17	180	426	0	606
[redacted]	29/03/16	1/06/16	10/07/17	10/07/17	64	404	0	468
[redacted]	18/06/16	20/08/16	11/07/17	11/07/17	63	325	0	388
[redacted]	1/07/15	30/09/15	11/07/17	11/07/17	91	650	0	741
[redacted]	4/09/15	30/09/15	11/07/17	11/07/17	26	650	0	676
[redacted]	2/10/15	11/11/15	11/07/17	11/07/17	40	608	0	648
[redacted]	17/12/15	8/01/16	11/07/17	11/07/17	22	550	0	572

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Comme
24/02/2017 10:18	[redacted]	Closed	Referral
24/02/2017 10:17	[redacted]	Accepted	Referral
01/06/2016 21:48	[redacted]	Received	Referral
11/03/2016 16:22	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Comme
24/02/2017 10:22	[redacted]	Closed	Referral
24/02/2017 10:20	[redacted]	Accepted	Referral
14/12/2016 11:32	Admin, Podiatry	Received	
18/10/2016 21:10	[redacted]	Received	Referral
23/08/2016 16:53	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Comme
15/03/2017 21:36	[redacted]	Closed	Referral
13/11/2015 11:33	[redacted]	Accepted	Referral
11/11/2015 07:41	[redacted]	Received	Referral
01/10/2015 11:49	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
10/07/2017 20:12	[redacted]	Closed	Referra
10/07/2017 20:11	[redacted]	Accepted	Referra
19/05/2015 16:08	[redacted]	Received	Referra
15/05/2015 14:39	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
10/07/2017 21:03	[redacted]	Closed	Referra
10/07/2017 21:02	[redacted]	Accepted	Referra
11/08/2015 08:15	[redacted]	Received	Referra
30/06/2015 13:08	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
10/07/2017 21:03	[redacted]	Closed	Referral
10/07/2017 21:02	[redacted]	Accepted	Referral
20/08/2015 09:11	[redacted]	Received	Referral
09/06/2015 12:40	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Commer
10/07/2017 21:48	[redacted]	Closed	Referral
10/07/2017 21:47	[redacted]	Accepted	Referral
10/05/2016 21:58	[redacted]	Received	Referral
12/11/2015 10:16	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Comme
10/07/2017 21:49	[redacted]	Closed	Referral
10/07/2017 21:47	[redacted]	Accepted	Referral
01/06/2016 21:48	[redacted]	Received	Referral
29/03/2016 12:43	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary | A

Date/Time	User	State	Comme
11/07/2017 13:48	[redacted]	Closed	Referral
11/07/2017 13:48	[redacted]	Accepted	Referral
20/08/2015 09:11	[redacted]	Received	Referral
18/06/2015 10:17	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
11/07/2017 13:49	[redacted]	Closed	Referra
11/07/2017 13:48	[redacted]	Accepted	Referra
30/09/2015 21:48	[redacted]	Received	Referra
01/07/2015 13:48	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

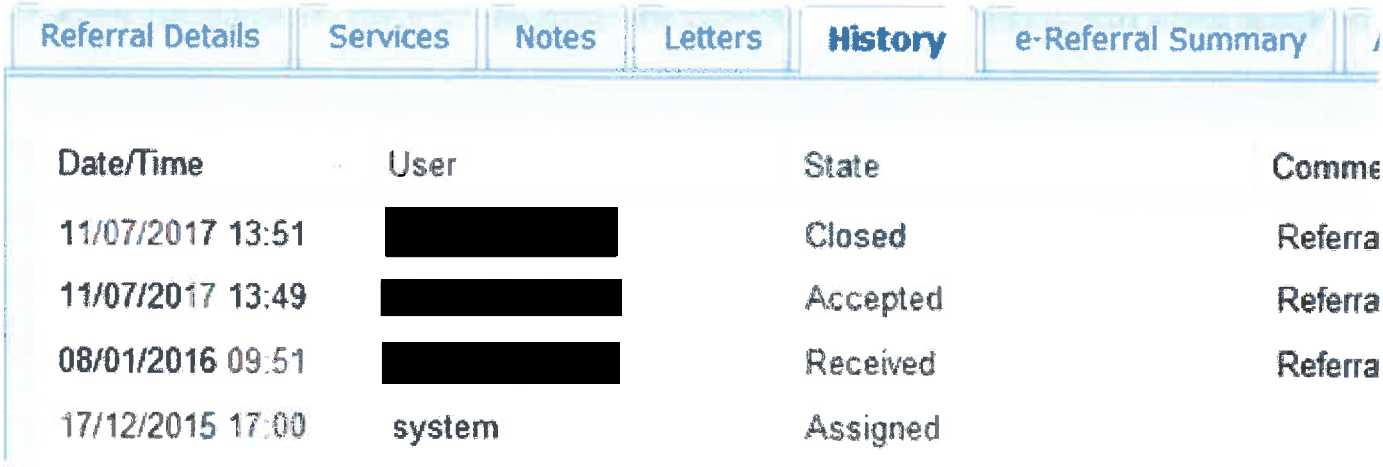
Date/Time	User	State	Comme
11/07/2017 13:50	[redacted]	Closed	Referral
11/07/2017 13:49	[redacted]	Accepted	Referral
30/09/2015 21:49	[redacted]	Received	Referral
04/09/2015 16:35	system	Assigned	

[redacted]

Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
11/07/2017 13:50	[redacted]	Closed	Referra
11/07/2017 13:49	[redacted]	Accepted	Referra
11/11/2015 07:41	[redacted]	Received	Referra
02/10/2015 16:45	system	Assigned	

[redacted]



Referral Details | Services | Notes | Letters | **History** | e-Referral Summary

Date/Time	User	State	Comme
11/07/2017 13:51	[redacted]	Closed	Referra
11/07/2017 13:49	[redacted]	Accepted	Referra
08/01/2016 09:51	[redacted]	Received	Referra
17/12/2015 17:00	system	Assigned	

Regards,

[redacted]
Diabetes Podiatrist |BHSc (Pod), PgDipHSc (Māori Health)
High Risk Foot Clinic | Whangarei Hospital |Hospital Road, PO Box 9742, WHANGAREI 0148
[redacted]

'There is nothing more unequal, than the equal treatment of unequal people.' - Thomas Jefferson.

From: [redacted] (NDHB)
Sent: Monday, 07 August 2017 4:56 p.m.
To: [redacted] (NDHB); [redacted]
Cc: [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB)
Subject: RE: Northland Diabetes Operational Working Group

Kia ora all,

As a matter of professional courtesy and to update you all about the concerns I raised in the email below, I have now escalated this matter and have lodged a complaint with the Health and Disability Commissioner today. It has been three weeks or 15 working days since I communicated these concerns and there has been no response or solution to address this particular patient safety issue or the quality of service deliverables. The basis of the complaint centres on [redacted] departure to provide services as is expected by the contents of Right 4 of the HDC Code of Rights and secondary failures of the Podiatry Referral Management System to address previously identified issues that may have contributed to this complaint.

Regards,

[redacted]
Diabetes Podiatrist |BHSc (Pod), PgDipHSc (Māori Health)
High Risk Foot Clinic | Whangarei Hospital |Hospital Road, PO Box 9742, WHANGAREI 0148
[redacted]

'There is nothing more unequal, than the equal treatment of unequal people.' - Thomas Jefferson.

From: [redacted] (NDHB)
Sent: Monday, 17 July 2017 5:30 p.m.
To: [redacted] (NDHB); [redacted]
Cc: [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB); [redacted] (NDHB)
Subject: RE: Northland Diabetes Operational Working Group

Kia ora Ian,

Thank you for taking the time to respond to my email response. I had referenced the lack of accountability because the accountability section was removed from the original ToR and is no longer in the new ToR. In my opinion, there has been no accountability for diabetes management within Northland across many levels of responsibility since my employment. The lack of podiatry service evaluations, reviews, performance measures, audits and quality reviews and some of the diabetes programmes reviews supports this view.

With your role as the funding manager for DCIP activity, I assume that the performance of DCIP programmes is therefore your responsibility and that these programmes are accountable to you? As I have commented in the email below, I do not have confidence that NDOW is the right forum to address matters of performance for DCIP programmes such as the community podiatry programme. Patient safety issues and problems endemic of this programme have persisted for the past three years, which suggests that NDOW and other entities are not being held accountable. Every member of NDOW including you and me are well aware of these issues because I have communicated these towards the NDOW group and others for the past three years without satisfactory resolution.

To support my comments, it is timely that I have received a fax from the [redacted] Medical Centre today advising that two patients had transferred from their practice to other practices in Whangarei. Attached to the fax were two community podiatry referral notifications (see attached). The fax should have been sent to the community podiatry service.

The notifications relate to two patients originally referred by their respective GP to the community podiatry programme in 2015. These referrals were viewed by the provider [redacted] podiatrist) 6 and 12 weeks later. This podiatrist has now arranged to see these patients last week (11/07/2017) which is **two years** after the referrals were originally sent.

1. NHI: [redacted] - referred 2/10/2015. Referral viewed 11/11/2015. Arranged first appointment 11/07/2017.
2. NHI: [redacted] - referred 5/07/2015. Referred viewed 30/09/2015. Arranged first appointment 11/07/2017.

This is a serious departure of expected delivery of funded health care services and accordingly, this poses as a serious patient safety risk as these patients are referred to the community podiatry programme as high risk patients with diabetic foot complications.

However, I find it more disconcerting that NDOW and the NDHB has failed to satisfactorily address issues I have continually communicated over the past three years that would have prevented this from happening:

1. I have previously communicated that I had concerns with [redacted] and his management of podiatry referrals - nil response.
2. I have persistently communicated that the podiatry referral system lacks proper management and clinical oversight (triaging) - response from December 2016 meeting that referral system to be taken in-house in April 2017 and then June 2017 has yet to be achieved.
3. I have previously communicated that there is no service specifications for service providers (podiatrists) - nil response or resolution.

4. I have recently communicated that there are patients who reside in Mangawhai who are unable to access NPHO community podiatry because of an impasse with respective PHOs (NDHB & WDHB) as to which is responsible for funding, despite patients residing in the NDHB catchment area - nil response.

These previous communications only relate to matters that I am made aware of, which suggests that there is likely to be other patient safety concerns or problems not identified or not addressed appropriately. As a result, I have included the patient safety and quality improvement directorate into this email thread given the implications from my previous reporting of patient safety concerns. I have seen a disconnect in this reporting process, particularly with the encouragement by the CEO and this organisation to report patient safety concerns in order to resolve and prevent further instances. The lack of reconciliation of these reported incidents suggests patient safety outside the hospital is viewed differently. I had previously reported a Datix incident in July 2015 to highlight the flaws in the podiatry referral system and 12 months later, these issues still persist.

Despite adding new membership to NDOW to 'strengthen accountability', there is still a core membership and existing key personnel who are well aware of the podiatry issues over a long period of time. This suggests that while we are all accountable as a group, no one really is accountable because it remains the responsibility of a faceless acronym - it is all our responsibility, but no one is responsible. Does this group have the expertise to undertake performance reviews to undertake accountability? I have often heard buzzwords such as RBAs, driver diagrams, performance measures/indicators, RCAs, audits etc. within the capacity of the NDOW forums over the years. However, I have only seen what they look like with colourful descriptions and have yet seen any that have been undertaken with any results. There is a podiatry driver diagram that was constructed less than three years ago and as I stated previously, it looks colourful on paper only.

Let me reiterate why I am so passionate and get frustrated with podiatry in Northland. I have assumed accountability of diabetic related limb amputations in Northland despite many contributing variables. Nevertheless, I use amputations as a performance measure and it can be used as the end point measure to evaluate the quality of screening, prevention and management programmes/services implemented to prevent amputations. Some will appreciate that I have face to face contact with most of the patients about to undergo amputations or who have recently had an amputation. In this regard, I become clinically and personally involved with these patients. Justifiably it is therefore my responsibility as the professional leader and expert to critically appraise health services that contribute towards the management of the diabetic foot. The purpose is to identify gaps in service delivery across the spectrum of the patient pathway that may not be delivering the expected outcomes or are otherwise perpetuating this serious health issue for many of our patients.

For six and a half years I have identified gaps in the SIA community podiatry programme, annual foot check compliance, MOH quarterly reports, and DCIP community podiatry programme which all relate to non-performance and patient safety issues. All these issues were communicated to the original LDT forum and subsequent NDOW group with others being privy to these concerns. Copies of my communications will support this. Despite me presenting these patient concerns, my concerns, data and reliable facts detailing these issues, the responses from members of both groups have ranged from; questioning the reliability of my patients' recollections; my expertise; and the data presented. The mere fact that these issues are still unresolved and are presented today, should therefore qualify my judgement to question the reliability of the function of the NDOW group to oversee the delivery of the DCIP & SIA podiatry contracts and management throughout Northland, given the unsatisfactory response and performance so far.

I will not accept an unsatisfactory response to patient safety and a substandard delivery of health care services for the diabetic foot in Northland within my capacity, as the consequences to inadequate patient care are too drastic, as ulcerations, complications, hospitalisations, amputations and mortality are likely outcomes. I challenge NDOW and its previous membership as to why it has been acceptable to date that these longstanding issues have been tolerated or disregarded? Had there been leadership and courage without competing interests to support my position over the years, these issues would have been remedied over four years ago or would not have become issues in the first instance. Perhaps some just don't care as much as I do what happens to my patients, who actually happen to be OUR patients!

I would like a satisfactory response (provider performance and patient safety) and solution to the two patients not being seen for two years from their initial referral to the community podiatry programme or alternatively the details

of the appropriate person, service or agency to escalate this issue. As I have previously expressed, NDOW is not the appropriate entity to oversee the performance of the podiatry contracts as there are still competing interests involved and outstanding matters are yet to be addressed.

Regards,

[redacted]

Diabetes Podiatrist | BHSc (Pod), PgDipHSc (Māori Health)
High Risk Foot Clinic | Whangarei Hospital | Hospital Road, PO Box 9742, WHANGAREI 0148
[redacted]

"What doesn't get measured, doesn't get managed."

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: Kathryn Leydon (NDHB)
To: Kathryn Leydon (NDHB)
Subject: FW: NDSAG Agenda and documents for 29 August 2018
Date: Wednesday, 13 February 2019 16:12:12
Importance: High

From: [redacted] (NDHB[redacted])
Sent: Tuesday, 28 August 2018 7:21 p.m.
To: [redacted]
Subject: RE: NDSAG Agenda and documents for 29 August 2018

Kia ora all,

Thank you for the agenda and attached documents. As I'll be at another meeting tomorrow, I submit the following comments to be tabled at this meeting.

I note from the agenda the objectives of NDSAG and in particular the following statement - *"To provide strong, clinical direction and leadership across the Diabetes sector."* Unfortunately and with respect to the management of community podiatry services across Northland for the past 10-years, I have seen little evidence to suggest that the clinical direction and leadership has been strong or effective.

On the 14 August 2012 I brought to the attention of NDOW that foot checks were not being undertaken as part of 'Get Checked' DARs and that the misreporting of completed DARs to the MOH was not accurate. At that time and in subsequent years, the number of patients (diabetes) without an annual foot check has remained constant at 30-40%. The reporting dashboard in the agenda documents for tomorrow's meeting confirms that the number of patients without a foot check in a 12-month period is approximately 41%, which suggests that this issue has worsened over the past 6 years. What direction has NDOW or NDSAG undertaken over this period to address this ongoing problem?

I have added much dialogue to this conversation which outlines what the consequences could look like from unchecked and unscreened diabetic feet. In the past financial year (2017/18), the Northland DHB region has seen a **57%** increase in the number of diabetes related amputations (DRLEAs) from the previous year. The number of patients affected by DRLEAs also increased by **30%**, however the increase for Maori patients was **58%** compared with non-Maori at 12% increase. 32 of the 43 (74%) patients who underwent a DRLEA(s) were not known to the HRFC or were referred for amputation by the HRFC within 7 days upon first appointment.

Years (1 Jul-30 Jun)	DRLEA	non-DRLEA	Total LEA	Maori DRLEA	Non-Maori DRLEA	Maori non-DRLEA	non-Maori non-DRLEA	Total Maori LEA	Total non-Maori LEA
2014/15	47 (73%)	17 (27%)	64	24 (51%)	23 (49%)	4	13	28	36
2015/16	43 (55%)	35 (45%)	78	21 (49%)	22 (51%)	2	33	23	55
2016/17	46 (71%)	19 (29%)	65	18 (39%)	28 (61%)	5	14	23	42
2017/18	72 (77%)	22 (23%)	94	32 (44%)	40 (54%)	1	13	33	53
Total 4yrs	208 (69%)	93 (31%)	301	95 (46%)	113 (54%)	12 (13%)	73 (87%)	107	186

Years (1 Jul-30 Jun)	DRLEA patients	non-DRLEA patients	Total LEA patients	Maori DRLEA patients	Non-Maori DRLEA patients	Maori non-DRLEA patients	Non-Maori non-DRLEA patients	DRLEA admissions	Non-DRLEA admissions	Total LEA admissions	Maori DRLEA admissions	Non-Maori DRLEA admissions	Maori non-DRLEA admissions	Non-Maori non-DRLEA admissions	Total Maori LEA admissions	Total non-Maori LEA admissions
2014/15	32 (71%)	15 (29%)	45	18 (56%)	14 (44%)	3	15	34 (68%)	16 (32%)	50	19 (56%)	15 (44%)	3	13	22 (44%)	28 (56%)
2015/16	32 (64%)	20 (36%)	50	15 (47%)	17 (53%)	2	20	35 (59%)	24 (41%)	59	17 (49%)	18 (51%)	2	22	19 (32%)	40 (68%)
2016/17	33 (67%)	16 (33%)	49	12 (36%)	21 (64%)	5	16	37 (70%)	16 (30%)	53	14 (38%)	23 (62%)	5	11	19 (36%)	34 (64%)
2017/18	43 (69%)	19 (31%)	62	19 (43%)	25 (57%)	1	18	54 (74%)	19 (26%)	73	24 (44%)	30 (56%)	1	18	25 (34%)	48 66%)
Total 4yrs	140 (66%)	70 (34%)	206	64 (46%)	77 (54%)	11	69	160 (65%)	75 (35%)	235	74 (46%)	86 (54%)	11	64	85 (37%)	150 (63%)

The information above sets the tone to support the following comments as the primary purpose of annual DM foot checks, and provision of community and secondary podiatry services is to reduce the number of diabetic foot complications such as DRLEAs. So, if foot checks are not improving, foot ulceration referrals to the HRFC are increasing significantly and the number of DRLEAs has increased as it has recently, how is NDSAG providing leadership and direction to preventing DRLEAs? The lack of confidence I have towards the leadership of the diabetes strategic group (past and present) is the intrinsic conflict of interest which has existed between managing and overseeing a community podiatry service and providing impartial oversight from the leadership of NDSAG because the roles are held by the same persons of responsibility and accountability. The Datix complaints (past and current), HDC complaint, internal reviews, Ministerial input and the impending external review of the community podiatry service supports the criticism that NDOW or NDSAG has been unable to separate the COI to effectively manage the service from the outset.

Recent developments to the community podiatry service due to the escalating budget costs has seen this leadership and direction reduce services to patients requiring this essential provision of service. Instead of fixing the service delivery by; reducing the service payment fees; reducing overpayments to providers; implementing long awaited service specifications; and improving referral oversight, the administration has sought to penalise patients by ignoring years (5 years) of complaints and recommendations of poor oversight and the impending budget blowout.

To justify the reduction of services in the current financial year, the attached treatment guidelines have been introduced as the basis for the new developments. Without any supporting documentation, clinical rationale, or references to support such changes in these guidelines, there is no clinical evidence or justification to support such changes. Furthermore, it is naïve and amateur to suggest that these guidelines should override the previously used guidelines which are endorsed by the MOH, NZSSD, PodSIG and the Northern regional podiatry network group. I see little evidence which puts the focus of these changes from a consumer or whanau centred approach. This is a fiscal response and is organisation centric by origin and nothing less.

I also question this leadership and direction when Maori ethnicity has been removed as a risk factor from the new guidelines. Obviously, there is a real lack of appreciation what equity actually looks like from this leadership. The removal of Maori as a risk factor without any reasoned justification is really poor direction and ill-informed decision making. This action will only perpetuate further inequities for Maori with diabetes and living in Northland. The above table supports this criticism as well as other national literature which I have included two recent studies I have co-authored. Additionally, my other preliminary research results indicate that Maori living in Northland have the highest relative risk (1.97) of DRLEA than non-Maori and is the highest than any other DHB from 1988-2015. Furthermore, more Maori patients living in Northland have had a DRLEA than any other DHB in the same time period. How does the leadership reconcile this evidence with the latest guidelines? Equity and equality are not the same and its best to ask those who really know the difference.

The following is another example of the direction of the NDSAG leadership which was applied to create more barriers to patients accessing health services (podiatry). Recently, the DHB renal teams and myself recognised that hospital haemodialysis patients had the poorest outcomes for amputation and mortality than any other health condition in Northland. Accordingly, all diabetes and haemodialysis patients were questioned with regards to their community podiatry service status - current service user?, previous user?, referred? etc. The information provided by these patients indicated that many had not been referred, had been referred but not seen, had been seen, but no longer seen, wanted to be referred or were currently being managed. The purpose of this proactive initiative was to enable access to community podiatry services for these patients who were not being referred or seen. Had these patients received regular foot checks and were referred because of their high and moderate risk conditions, this undertaking would not have had to be undertaken by busy hospital services and staff. However, we saw the benefit to being proactive in order to prevent increasing admissions to hospital for this cohort. Subsequently, I referred at least 26 patients from this initial analysis to the community podiatry service using the referral form on the basis that all qualified because of their listed risk criteria. Admittedly, not all boxes were completed, but more crucial risk factors superseded that requirement.

Unfortunately, these referrals were rejected for a range of excuses, but fundamentally that the referrals should originate from the patients' respective GPs. Yes, more unnecessary barriers for patients to access diabetes health care services such as community podiatry service due to budget constraints. Solutions without substance are merely rhetoric, 'white noise' or as [redacted] describes as "fog" which essentially is new speak for barriers for those who know what to do from those who purportedly at the other end.

Years (1 Jul-30 Jun)	Renal LEA	Total LEA	Maori renal LEA	Non-Maori renal LEA
2014/15	38 (59%)	64	17 (45%)	21 (55%)
2015/16	36 (46%)	78	15 (42%)	21 (48%)
2016/17	30 (46%)	65	16 (53%)	14 (46%)
2017/18	37 (24%)	94	17 (46%)	20 (54%)
Total 4yrs	141 (47%)	301	65 (46%)	76 (54%)

Years (1 Jul-30 Jun)	Renal patients	Total LEA patients	Maori renal patients	Non-Maori renal LEA patients	Renal LEA admissions	Total LEA admissions	Maori renal LEA admissions	Non-Maori renal LEA admissions
2014/15	25 (56%)	45	12 (48%)	13 (52%)	26 (52%)	50	13 (50%)	13 (50%)
2015/16	16 (32%)	50	8 (50%)	8 (50%)	25 (42%)	59	12 (48%)	13 (52%)
2016/17	13 (27%)	49	8 (62%)	5 (38%)	22 (42%)	53	12 (55%)	10 (45%)

2017/18	20 (47%)	43	9 (45%)	11 (55%)	27 (37%)	73	13 (48%)	14 (52%)
Total 4yrs	74 (40%)	187	37	37	100	235	50	50

It's important to remember that I sit closer to the action to appreciate what the real consequences of diabetic foot complications looks like, smells like and feels like from the patients' perspective. And it's easier for us (patients and myself) to identify further up the pathway where improvements can be made than those without any appreciation of what patient centred care REALLY looks like! Do what's best for the patient, than for the organisation or yourself.

Regards,

[redacted]
Diabetes Podiatrist | BHSc (Pod), PgDipHSc (Maori Health)
High Risk Foot Clinic | Whangarei Hospital **|** Hospital Road, PO Box 9742, WHANGAREI 0148
[redacted]

'There is nothing more unequal, than the equal treatment of unequal people.' - Thomas Jefferson.

[redacted]

From: Kathryn Leydon (NDHB)
To: Kathryn Leydon (NDHB)
Subject: FW: NDSAG Agenda and documents for 29 August 2018
Date: Wednesday, 13 February 2019 13:43:05
Attachments: image005.jpg
ATT00001.htm
image006.jpg
ATT00002.htm
SKMBT_C284e18083014271.pdf
ATT00003.htm
.msg
ATT00004.htm

From: [redacted]
Date: 30 August 2018 at 8:06:36 PM NZST
To: [redacted]
Cc: [redacted]
Subject: RE: NDSAG Agenda and documents for 29 August 2018

Kia ora [redacted] and others,

Unfortunately, I am hearing the same response which is becoming repetitive and hollow in regards to improvements that are supposedly being made to the community podiatry programme.

Further to my email and in response to **three** referrals my service received **today.**

My service is not prepared to receive referrals for patients who can no longer be managed in community podiatry service because they have '*used up*' their allocated number of treatment sessions. The fundamental purpose of **ALL**

community podiatry services is to manage these patients in the community so that diabetic foot complications are prevented to avoid hospitalisations, surgery or secondary services.

As outlined in my email below, my service is already experiencing an increasing caseload for **ACTIVE** diabetic ulceration patients and my service does not have the capacity to pick up the slack of the Northland community podiatry service because the management of that service is unable to manage this cohort of community funded patients as was expected by the MOH. Poor decision making has led to this new problem and was very predictable.

The other referral relates to a patient not followed up by the community podiatrist as planned (see details below). The same podiatrist is subject to a current Datix incident for not following up on a referral for a high risk patient for **7 months** and there may be others, but there appears to be no action was undertaken follow of the report of such and today's referral as confirmation. This is concerning, as this patient safety issue is not new and has been known since 2016. This follows on from a desktop audit of another podiatrist which showed that the podiatrist failed to act on 28 patient referrals which ranged from **166 to 751** days. Following this, another community podiatrist was subject to a HDC complaint because that person failed to act on 11 patient referrals for periods of **187 to 787** days. This is a serious departure from expected referral management by the contract holder, and so it continues.

The last referral (as attached) and as you can see in the dialogue, the patient was not seen as was expected by the same podiatrist named in the second referral. This patient has now presented with an active diabetic foot ulceration. So, where is the prevention or provision of services as is expected from the service specifications, if there is one?

So, despite all the concerns raised via emails, Datix incidents and HDC complaint to NDOW, NDSAG and persons with responsibilities for the community podiatry contract over the past 4 years, little improvement if any has been seen and this supports my lack of confidence for those responsible of this contract because of the impact on patients and hospital services including mine.

Ian, this additional information would therefore contradict your statement today and demonstrate that the actions of NDSAG are not upholding its role "*to improving the service which diabetic patients receive in Northland. Putting the patients are the heart of the service.*" Today's referrals show that there is absolutely no improvement or putting patients first despite the reviews and recommendations from those incidents and complaints that were undertaken and overseen by members of NDSAG or managers of that contract.

So that I know that you are aware of the consequences of these failings, I invite you to come sit in on one of my clinics to look at the impact of these diabetic foot complications, otherwise I can provide you with patient or whanau details so that you can explain to them what improvements have been made;

1. The whanau of the 39 year patient who was referred to community podiatry (28 Jul 2017) but was not seen as the referral was rejected because the patient had an ulcer, but was not re-referred to the HRFC. That patient presented a month later to ED on three occasions before transferring to ACH for foot and BKA, prior to mortality at ACH.
2. The partner of the patient (now deceased) who was referred to community podiatry (29 Sep 2017) with an ulcer, but was not seen as the referral was rejected because patient had an ulcer, but was not re-referred to HRFC despite instructions to do so. When patient was seen by HRFC on 3 November 2017, following referral from another hospital clinician, patient was sent to ACH for amputation of exposed bone in toe. 23 days after discharge and when seen at HRFC for follow up, I was the last person to see patient alive before he went home and died.
3. The vascular surgeon who alerted to me that a patient seen in his clinic was referred to community podiatry in February this year had a vac dressing over amputations of the right 3/4/5 toes. This patient was seen by a community podiatrist and only the left foot was assessed because of the vac dressing. This patient continued to receive vac dressing therapy from February to 7 May (11 weeks) when this was removed by vascular surgeon. The vascular surgeon was not impressed that the patient was receiving this treatment for this length of time, but that the patient had not been referred to HRFC. Why would an amputation wound be referred to community podiatry and why wouldn't community podiatrist refer to HRFC? Because it's the Northland community podiatry service?
4. The patient and family of the person currently in our rehab ward after undergoing a BKA at ACH recently. The same person who had a foot ulcer since December 2017 and was seen on two occasions by a community podiatrist during the six months before patient was transferred to ACH when admitted to WHG ED. The same podiatrist that the desktop audit was undertaken on in December 2017 and who didn't refer to HRFC or vascular services during this period.

If you're happy to explain to these persons that NDSAG has made improvements as you indicated would, then I would take your response as having merit. However, I have attached your response from an email dated October 2017 as a reminder to you of concerns you considered at that time had been resolved or would be improved. Twelve months later, I see little improvement has been achieved and this will only worsen because of recent developments to that programme as detailed today from the new referrals.

The only way NDSAG will appreciate the severity of this ongoing problem is to put a loved family member in the place of the patients listed above. Would you be happy that your 39 year old partner, sister, brother underwent this treatment or any of the other circumstances? Not likely, so why is NDSAG sitting on its hands or head in the sand when it comes to fixing this well known problem for patients at the heart of the primary function? Because it doesn't affect you personally or that these patients are not in your care?

As previously stated, I have seen little to provide any confidence that NDSAG is fulfilling its obligation and objectives towards community podiatry services.